STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citation represent the finding of a Health Resurvey.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility had a census of 22 residents with one dining room. Based on observation, interview, and record review, the facility failed to maintain or enhance each resident's dignity during dining by using Styrofoam containers during meals and using the clothing protector to wipe a resident's mouth instead of a napkin (#6). Findings included: - During an observation on 8/4/14 at 12:33 p.m., staff served a fruit dessert in Styrofoam, disposable containers to the residents in the dining room that wanted dessert. During an observation on 8/6/14 at 11:15 a.m., dietary staff D cut the chocolate layered dessert and placed the dessert servings in Styrofoam containers for the noon meal. At 12:15 p.m., dietary staff E served the desserts to the residents in the dining room in Styrofoam, disposable containers to those that wanted the	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1	F 241		

desserts. Not all residents chose the dessert as part of their meal.

An interview on 8/6/14 at 11:15 a.m. with dietary staff D revealed the facility started using the disposable containers for dessert because the containers could be thrown away and since the dietary department was "short staffed" , it was more convenient. Staff D further stated sometimes they ran out of the dishes used for desserts.

During an interview on 8/6/14 at 4:00 p.m., administrative nurse B stated he/she did not know why they started using the disposable containers for desserts, but thought it may be due to not having enough dishes.

The facility failed to serve food to residents in dignified, homelike manner when dietary staff served desserts to residents in Styrofoam, disposable containers.

- During an observation on 8/6/14 at 12:14 p.m. direct care F sat with resident #6 and assisted him/her with the noon meal. Staff F gave resident #6 a bite of mashed potatoes, and then wiped the resident ' s mouth with his/her shirt protector. The resident had a paper napkin available, as well as a tissue box on the table. At 12:28, resident #6 used the shirt protector to wipe his/her nose. At 12:35 p.m. the resident again wiped his/her nose with the shirt protector. At 12:37 p.m., direct care staff F gave resident #6 a bite of chocolate layered dessert, then wiped his/her mouth with the shirt protector that the resident used to wipe his/her nose.

During an interview on 8/6/14 at 2:02 p.m., direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 care staff F stated he/she was unaware that he/she used the shirt protector instead of a napkin or tissue to wipe resident #6's face during dining. During an interview on 8/6/14 at 4:00 p.m., administrative nurse B confirmed that when staff assist residents with meals they should use the napkins available instead of the shirt protectors to clean the resident's face or mouth. The facility's undated Resident Rights stated, as a resident you have a right to be treated as a person with respect, dignity, and consideration. The facility failed to assist resident #6 with dining in a dignified manner when staff used the resident's shirt protector to clean his/her face instead of using an available napkin.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 3 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility had a census of 22 residents with 12 sampled for review. Based on observation, interview, and record review the facility failed to review/revise 1 resident's nursing care plan with fall prevention strategies in order to prevent accidents. (#22) Findings included: - Resident #22's 7/11/13 significant change MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 15 which indicated intact cognition. The resident performed ADLs (captivities of daily living) independently except for supervision when off of the unit. The resident had steady balance and used a walker for mobility. The resident had no falls since the prior assessment and received antipsychotic, antidepressant, and diuretic therapy during the assessment period. The 7/16/13 Fall CAA (care area assessment) identified the resident as at risk for falls due to his/her use of psychotropic medications that may result in dizziness. According to the CAA, he/she tended to lean forward when walking, but had a steady gait. Resident #22 7/12/14 Annual MDS revealed a BIMS of 15 indicating cognition intact with no	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4	F 280		

behaviors. According to the assessment, the resident performed all ADLs independently. The resident had unsteady balance, but had the ability to stabilize without assistance from staff. The resident had no functional limitations in range of motion and used a walker for mobility. The assessment indicated the resident had 2 or more non-injury falls since the prior assessment. The MDS also revealed resident #22 received antipsychotic, antianxiety, antidepressant, and diuretic medications for 7 days of the assessment period.

Resident #22 7/23/14 Fall CAA (care area assessment) revealed the resident walked with a walker and was unsteady with rising and ambulation, but was able to steady him/herself without staff assistance. The Fall CAA revealed the resident was at risk for falls due to the use of psychotropic medications that may result in dizziness. The resident had 3 falls in the past quarter and all within a 2 week period. The CAA further stated the resident ambulated with a walker, tended to lean forward, and shuffled his/her feet at times. The CAA also indicated the resident received restorative therapy.

Resident #22's 2/15/14 care plan last reviewed on 7/4/14 revealed the resident was independent with ADLS. Revisions to the care plan directed staff to ensure resident wore shoes "on all the way" on 8/7/13, resident to wear shoes when out of his/her room on 5/27/14, educated to call for help before getting out of bed on 8/1/13, and directed staff to check with the resident to see if he/she needed assistance on 8/2/14. Review of the care plan lacked revision to the care plan after the resident sustained falls on 7/24/13, 9/18/13, and 6/4/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5 Review of the facility's fall investigations revealed the resident fell on 7/24/13, 9/18/13, and 6/4/14. During an observation on 8/5/14 at 7:38 a.m., resident #22 walked independently with his/her walker leaning forward with a steady gait from the dining room to his/her room. During an interview on 8/7/14 at 9:05 a.m., administrative nurse B confirmed each fall should be evaluated for causal factors and fall prevention strategies should be placed to prevent future falls. Nurse B further verified that resident #22's care plan did not reflect the recommendations to prevent falls identified in the fall investigations. He/she also confirmed that after the resident fell on 6/4/14, he/she fell again on 6/9/14 prior to any changes in medications that may have contributed to the resident's falls. The facility's undated Falls policy stated staff would identify residents at high risk for fall per the fall risk assessment and initiate procedures for care of those residents at high risk and those that have fallen. A plan to minimize falls should be in the care plan an updated as needed with staff education regarding factors for minimizing falls. The facility failed to review/revise resident #22's nursing care plan with fall prevention strategies.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6	F 323		

prevent accidents.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 22 residents with 2 reviewed for accidents.

Based on observation, interview, and record review, the facility failed to ensure 1 of 2 residents sampled for accidents received adequate supervision to prevent accidents (implementation of appropriate fall prevention strategies). (#22) The facility also failed to ensure the residents' environment remained free of accident/hazards (chemicals in areas accessible to residents) for 8 cognitively impaired independently mobile residents.

Findings included:

- During an initial tour of the facility on 8/4/14 at 8:56 a.m. the west hall bath house had an unlocked cabinet that contained a spray can of Betco disinfectant labeled "Keep out of reach of children" .

During an interview on 8/4/14 8:56 a.m., administrative nurse B verified the disinfectant should be locked up and stated staff forgot to lock the cabinet. Nurse B then removed the disinfectant from the area.

An observation on 8/6/14 at 4:08 p.m. in the west hall bath house revealed an unlocked cabinet that contained a spray bottle that contained a yellow liquid with a handwritten label identifying the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

product as "PH7Q" (Betco disinfectant). The handwritten label failed to include warnings. According to the manufacturer ' s Betco PH7Q product label, the chemical had a danger warning as corrosive and caused irreversible eye damage and skin burns. The warning also stated the chemical was harmful if swallowed and recommended that users wear protective clothing, eyewear, and gloves when using the product. The label also contained the warning "Keep out of reach of children".

During an interview on 8/6/14 at 4:10 p.m. direct care staff F reported that he/she saw the spray bottle in the bath house cabinet earlier in the morning, but did not know what was in the bottle. Staff F thought housekeeping used this product. Direct care staff F later reported housekeepers used the product identified as PH7Q and removed the product from the unlocked cabinet.

During an interview on 8/6/14 at 4:16 p.m., administrative nurse B confirmed hazardous housekeeping products should not be stored in unlocked cabinets accessible to residents.

The facility's Maintenance Department Policy dated 11/04/03 stated any cleaning compounds or poisonous chemicals should be kept in locked cabinets/storage when not in use and should not be left unattended when not in use.

The facility failed to store hazardous chemicals in areas inaccessible to 8 cognitively impaired, independently mobile residents.

- Resident #22's 7/11/13 significant change MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8	F 323		

status) score of 15 which indicated intact cognition. The resident performed ADLs (captivities of daily living) independently except for supervision when off of the unit. The resident had steady balance and used a walker for mobility. The resident had no falls since the prior assessment and received antipsychotic, antidepressant, and diuretic therapy during the assessment period.

The 7/16/13 Fall CAA (care area assessment) identified the resident as at risk for falls due to his/her use of psychotropic medications that may result in dizziness. According to the CAA, he/she tended to lean forward when walking, but had a steady gait.

Resident #22 7/12/14 Annual MDS revealed a BIMS of 15 indicating cognition intact with no behaviors. According to the assessment, the resident performed all ADLs independently. The resident had unsteady balance, but had the ability to stabilize without assistance from staff. The resident had no functional limitations in range of motion and used a walker for mobility. The assessment indicated the resident had 2 or more non-injury falls since the prior assessment. The MDS also revealed resident #22 received antipsychotic, antianxiety, antidepressant, and diuretic medications for 7 days of the assessment period.

Resident #22 7/23/14 Fall CAA (care area assessment) revealed the resident walked with a walker and was unsteady with rising and ambulation, but was able to steady him/herself without staff assistance. The Fall CAA revealed the resident was at risk for falls due to the use of psychotropic medications that may result in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

dizziness. The resident had 3 falls in the past quarter and all within a 2 week period. The CAA further stated the resident ambulated with a walker, tended to lean forward, and shuffled his/her feet at times. The CAA also indicated the resident received restorative therapy.

Resident #22's 2/15/14 care plan last reviewed on 7/4/14 revealed the resident was independent with ADLS. Revisions to the care plan directed staff to ensure resident wore shoes "on all the way" on 8/7/13, resident to wear shoes when out of his/her room on 5/27/14, educated to call for help before getting out of bed on 8/1/13, and directed staff to check with the resident to see if he/she needed assistance on 8/2/14.

Resident #22's fall risk assessments completed on 7/5/13, 10/12/13, 1/7/14, and 4/13/14 indicated the resident was not a fall risk. A fall risk assessment completed on 5/29/14 revealed the resident had a score of 10, placing the resident at higher risk for falls. An assessment on 6/9/14 revealed a score of 14, indicating a continued high risk for falls.

A fall documentation form dated 7/24/13 revealed resident #22 reported he/she fell in his/her room when he/she turned away from the sink and he/she could not reach his/her walker. Related factors included failure to use the call light and included an intervention for patient teaching regarding call light use.

Fall documentation dated 9/18/13 at 11:20 p.m. revealed resident #22 reported he/she fell in his/her room. Contributing factors identified included failure to use the call light. The intervention implemented on the form stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

resident to call before getting out of recliner. Review of the care plan lacked revision with the intervention recommended in the fall documentation.

Resident #22's 6/4/14 fall investigation worksheet stated staff found the resident on the floor with no injuries. The resident stated he/she was trying to get dressed and fell. A recommended intervention on the worksheet stated the resident's room was too small for his/her personal items and also indicated a recent increase in the resident's narcotics and recommended a medication review by the physician. Review of the care plan lacked revision with the recommended environmental interventions or completion of a medication review by the physician.

A fall investigation dated 6/9/14 revealed resident #22 fell after eating. According to witnesses, the resident grabbed the door to the "rose" room (quiet room) and lowered him/herself to the floor at 12:55 p.m. Recommendations on the worksheet indicated the resident's narcotic was increased about 2 weeks ago. The care plan included a revision on 6/10/14 with a decrease in the resident's antipsychotic and antianxiety medications.

During an observation on 8/5/14 at 7:38 a.m., resident #22 walked independently with his/her walker leaning forward with a steady gait from the dining room to his/her room.

An interview on 8/5/14 at 3:17 p.m. with direct care staff F revealed resident #22 currently ambulated independently and stated that in the past his/her shoes or clothing contributed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 his/her falls. During an interview on 8/7/14 at 9:05 a.m., administrative nurse B confirmed each fall should be evaluated for causal factors and fall prevention strategies should be placed to prevent future falls. Nurse B further verified that resident #22's care plan did not reflect the recommendations to prevent falls identified in the fall investigations. He/she also confirmed that after the resident fell on 6/4/14, he/she fell again on 6/9/14 prior to any changes in medications that may have contributed to the resident's falls. The facility's undated Falls policy stated staff would identify residents at high risk for fall per the fall risk assessment and initiate procedures for care of those residents at high risk and those that have fallen. A plan to minimize falls should be in the care plan an updated as needed with staff education regarding factors for minimizing falls. The faciltiy failed to review each of resident #22's falls for causal factors and implement fall prevention strategies in order to prevent future falls.	F 323		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 12	F 520		

committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 22 residents.

Based on interview and record review the facility failed to conduct an ongoing Quality Assessment and Assurance (QAA) committee that included designated key members of the facility staff that met at least quarterly.

Findings included:

Review of the QAA committee sign-in rosters for monthly QAA meetings revealed the committee met monthly from July of 2013 until October of 2013 with the director of nursing, a physician, and at least 3 facility staff in attendance. Review of the sign-in rosters for October 2013 until May 2014 revealed the committee met without the required members in attendance, a period of 7 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 13 During an interview on 8/7/14 at 10:21 a.m., administrative staff G stated he/she was unaware of the requirements related to key members of the QAA committee. Staff G further revealed the committee met monthly and confirmed the meeting rosters from October 2013 to May of 2014 verified a lack of attendance of the required members for a period of 7 months. The facility's QAA committee failed to meet at least quarterly with the required key members of the committee in attendance.	F 520		